Dr. Sean W. Lazarus DPM, Medical Director

WEST HAVEN FOOT AND ANKLE CENTER

764 Campbell Avenue, Suite G — West Haven, CT 06516
Office: (475) 238-7400 Fax: (475) 238-7982
Email: drseanlazarus@gmail.com
www.WestHavenFootAndAnkle.com

Patient Information

First Name | Middle Initial | Last Name

Sex M F | Date of Birth | Social Security Number | Marital Status

Address | City | State | Zip

Home Phone | Mobile Phone | Email Address

Preferred Method of Contact
☐Home Phone Call ☐Cell Phone Call ☐Cell Phone Text Message ☐Cell Phone Call ☐Other: ________________________

Primary Care Physician | Primary Care Physician Phone

Referred By | Referring Physician Phone

Pharmacy Name | Pharmacy Address | Pharmacy Phone

Meaningful Use Information

Race
☐American Indian/Alaskan Native ☐Asian ☐Native Hawaiian/Pacific Islander ☐Black/African American ☐White/Caucasian ☐Hispanic
☐Other: ______________________ ☐Refuse to report

Ethnicity
☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Refuse to Report/Answer

Preferred Language
☐English ☐Spanish ☐Russian ☐Indian ☐Other: ___________________

Emergency Contact Information

Emergency Contact Name | Emergency Contact Phone | Relationship to Patient

Patient Employer/School Information

Employer/School | Occupation | Employer/School Phone

Employer/School Address | City | State | Zip

Billing and Insurance

Insurance Company | Insured Name | Insured Date of Birth | Relationship to Insured

Insurance Address | City | State | Zip

Secondary Insurance Name (if applicable) | Insured Name | Insured Date of Birth

The information provided is true to the best of my knowledge.

Patient Name *(please print)*: ______________________________________ **Patient's Guardian** *(if applicable, print)*: ____________________________________

Patient's or Guardian Signature: ____ **Date:** ___________________________________